

13 Nov 68

INCIDENT INVESTIGATION 057

SECRET

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25X1A

TO: 

SUBJECT: Incident Report 057

1. Attached is forwarded per our conversations and your instructions.
2. Realize that we have been slow in pulling this report together and to you - my only excuse is that all of us here are placing priority on being ready for 14 January.
3. On reviewing the attached report, I am pleased. It is subjective, informative and honest.
4. The video film on this incident is invaluable. Anytime you and your people in headquarters would like to see it, I can send an officer with the equipment to your headquarters for review.

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REPLY TO

ATTN OF: Operations [REDACTED] Investigating Officer)

SUBJECT: Incident Report 057

21 November 1968

TO: Commander

1. The following is an informal incident report of the investigation into the landing incident that occurred at [REDACTED] on 13 November 1968.

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- a. Pilot: [REDACTED]
- b. Mobile Officer; [REDACTED]
- c. Operations Officer: [REDACTED]
- d. Article involved: 057

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2. Attachments:

- a. Statement by [REDACTED]
- b. Statement by [REDACTED]
- c. Statement by [REDACTED]
- d. Medical Officers Report.
- e. Maintenance Report (LAC Engineers)
- f. Photographs.
- g. Video tape of incident available for viewing.

3. Pilot experience in this model: 4 flights, 11.4 hours.

4. Narrative of Event:

a. Flight activity up until the time of touch down in the landing phase was uneventful. Weather at the time of landing was clear with winds variable at 3 (three) knots maximum. This entire incident was recorded on video T.V. Movie tape with excellent quality.

b. The pilot made a standard 360° overhead traffic pattern to runway 24 at North Base. Final approach was normal with good air-speed and glide path control observed - power was reduced to idle over runway threshold at a height of approximately five feet and at this time the mobile officer began giving the pilot height above the runway over the radio.

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c. Height references were continued until the aircraft was approximately one foot above the runway; shortly thereafter, the left wing appeared to drop rapidly. The left wing tip contacted the runway almost simultaneously but slightly after the gear (main and tail wheels touched at the same time). Touch down was in the center of the runway, 800 feet from the approach end. Immediately upon touchdown the aircraft began a violent left turning skid leaving the runway 1600 feet from the approach end coming to rest 100 feet off the runway, heading 90 degrees to the runway heading.

d. Immediately after touch down the mobile officer, recognizing an uncontrolled situation developing, gave two instructions over the radio, first asking for full right rudder and then seeing that the aircraft would leave the runway, he instructed the pilot to stopcock. These instructions were promptly complied with by the pilot. The aircraft main gear buried itself approximately 18 inches in desert sand on coming to rest. Pilot egress was assisted by ground personnel. After on the spot investigation to ascertain gear integrity, maintenance personnel cleared a small trench, lined it with boards and towed the aircraft out of the sand back on the runway- then to the ramp.

e. Aircraft configuration at landing was: speed brakes extended, flaps 35 degrees, stall strips extended, gear down and locked. Fuel on board 176 gallons with 50 gallons in the sump. Upon reaching the aircraft, immediately after it came to rest, the ground crew found the left wing heavy. Video tape shows left wing landing spoiler up at touchdown - right spoiler action cannot be observed in the film, however post flight inspection indicated right spoiler operating normally. Video film also shows full right rudder and full right aileron being applied by the pilot throughout the rollout. The pilots' statement indicates that fuel transfer from left to right was required "maybe every twenty or thirty minutes". Form 781 carried the following outstanding discrepancy "excessive fuel transfer required left to right in the outboards".

25X1A f. In interviewing [REDACTED] who entered this discrepancy and who also briefed David prior to this flight in this article, he states that the rate of transfer that was accomplished by David was insufficient for this aircraft. [REDACTED] also states that this discrepancy was thoroughly covered by him during the mission briefing.

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g. Davids' statement indicates that no specific fuel transfer was required, to obtain lateral stability, just prior to pattern entry.

h. Video tape and eye witness testimony indicates that the aircraft was in a full stall condition just prior to touchdown and there is some indication that a left yawing moment was initiated, probably due to left wing heavy, just prior to the aircraft making contact with the runway. This yawing moment uncorrected by the pilot coupled with immediate left wing dragging created a left turning rate that could not be overcome with controls available by the pilot after the main and tail gear was firmly on the runway.

NOTE: Project Headquarters Directive 50-10-30 requires voice talk-down procedures to be utilized at least through the fifth training mission for initial U-2 qualification however, the [REDACTED] policy to talk-down U-2R transition pilots on a proficiency basis.

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5. COMMENTS:

a. When a discrepancy of lateral instability exists in the form 781 how does a pilot know how much transfer is required?

b. This discrepancy was thoroughly explained to the pilot prior to the mission and he was instructed to effect fuel transfer prior to traffic pattern entry - apparently David did not transfer probably because an "out of balance condition" was not recognizable.

c. The aircraft was landed in a full stall condition caused by holding it off too long and at the last moment excessive back stick pressure was applied just prior to touch down.

6. PROBABLE CAUSE: Violent wing drop during the touchdown phase at time of stall, caused by improper fuel balance and some degree of aircraft lateral instability, aggravated by excessive, pilot induced back pressure in the roundout - resulting in a full stall condition prior to contact with the runway; accompanied by loss of directional control.

7. CONTRIBUTING CAUSE: Pilot apparently failed to properly balance fuel prior to landing in accordance with the specific mission briefing for this particular aircraft.

8. RECOMMENDATIONS:

a. Until such time that all "R" articles are modified with the auto fuel balancing lines (see service bulletin 58), every caution should be taken to insure proper fuel balancing just prior to landing.

b. That pilots be rebriefed on correct landing procedure, with emphasis on the roundout and touchdown phase.

c. When a specific chronic situation of any instability is noted in one of the articles, that article be returned to IAC for corrective action.

d. Prior to releasing aircraft 057 operationally ready, recommend an experienced IP fly this aircraft through several touch and go landings to determine that no adverse landing characteristics exist.

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DEBRIEFING: FLIGHT 057 - DAVID - 13 NOV 68

[REDACTED] OK boys. This is in reference to the incident we had today in 057 and all we want you to do is tell us in your own words, say from what happened in the initial flight until you got out of the airplane. As you can remember as it happened in sequence, and then I was listening to the radio and I can remember some of the conversation that went on also, so if you can just tell us what you thought happened and what did happen so we can use this for our de-briefing.

David: Initial everything was alright I started.....drag the bird in because of turbulent air and I made a big pattern and down the finaland everything I said was all lined up. 85 knots on final and little Joe told me, he said 4 feet, 2 feet.....spoiler and all of a sudden I noticed it still didn't come up and I waited a little while and touched down and also the nose started to drift to the left and I couldn't control it and I keep going to the left and went off the runway.

25X1A

[REDACTED] Did you notice in flight you had to transfer fuel excessively from left to right?

David: Yes I had to. After maybe 20 or 30 minutes transfer from left to right.

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[REDACTED] Every 2 or 3 minutes.

David: 20 or 30 minutes.

25X1A

[REDACTED] 20 or 30 minutes OK.

David: When I realized the bird was off the runway I looked at the control box.....keep the bird straight prevent damage and hit the brakes..... to stop and I don't remember anything when I stopped except I stopcock the engine and turn the battery switch off thats what I remember till [REDACTED] or some PE guys come and got me.....I was so dizzy and....and my back hurt.

25X1A

[REDACTED] Did you get jostled around in the cockpit when the aircraft went off the runway.

David: Yes.

25X1A

[REDACTED] Do you think you might have hit your head?

David: I don't know, it happened so quick.

25X1A

[REDACTED] Do you know if the shoulder harness was locked?

David: It was unlocked.

25X1A

[REDACTED] It was unlocked?

David: I think so.

25X1A

[REDACTED] The rest of the flight went normally though except that you did have to transfer fuel about every 20 or 30 minutes.

25X1A

David: Yes.

[REDACTED] I was listening on the radio and I noticed Jim said: make his first call, he was giving you height above the ground 3 feet, 2 feet and then 1 foot and then he give you the right rudder. When you were about 1 to 2 feet did it feel like either wing dropped excessively on touch down, or just prior to touch down.

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David: No, I dont remember that.

25X1A

[REDACTED] You dont' remember that?

David: No.

[REDACTED] There's nothing else you can think of that you can remember now.

25X1A

David: No it was a very pleasant flight today, course you can't see much down on the ground it was all overcast.....

25X1A

[REDACTED] How was your speeds on final? Were they.....

David: Final was.....85 knots max.

25X1A

[REDACTED] 85 knots on final.

David: Yes, my speed was slowed up it was 76, 78 something.

25X1A

[REDACTED] Ok Dav. Bill can you think of anything that you might want to add?

Andy: You mentioned about right rudder that's after touch down?

25X1A

[REDACTED] Yes.

Andy: After touch down Jim give the right ridder.

25X1A

[REDACTED] Yes.

Andy: Then stopcock.

[REDACTED] He called 3, 2, 1 foot and then right rudder.

25X1A

Andy: Yea, one foot he already touch down then I think the wing dropped you know back on the runway and the.....had tendency to turn to the left, and he say right rudder, and he also give stopcock.

25X1A

[REDACTED] There's no chance to go around I guess?

Andy: No, worse thing to do.

[REDACTED] I think the point by then it had turned so much to the left that.....

25X1A

Andy: I don't think he had any chance to go around. No, I don't think so. Very quick you know.....

How about ailerons, any effective aileron?

25X1A

Andy:Do you remember did you try to pick up wing from left.

David: Yes.

25X1A

You tried right aileron to pick up left wing but you couldn't get it up. The left wing down like that.....

Andy: The left wing was down steady down, couldn't pick up.

What about crosswinds?

25X1A

Andy: No crosswinds. From my point of view only 2 or 3 knots headwind. The wind sock straight down runway only about 2 or 3 knots at the most. Very calm winds.

25X1A

OK David I guess the doctors going to put you in hospital for observation over night tonight just for observation.

Andy: Just for observation no problem there.

OK Dave we won't bother you any more. Thank you.

STATEMENT [REDACTED]

25X1A

13 November 1968

25X1A

Following is brief narrative concerning landing incident, aircraft 057, pilot [REDACTED] on 13 Nov 1968

Aircraft turned final at 1358 local, correctly configured, prepared for normal landing. Winds and final were calm. As aircraft passed over threshold, winds were 2 or 3 knots, or less. Direction was down the runway.

The pilot had made a comment on the break-that there was a little turbulence at pattern altitude.

Flareout was normal as the aircraft passed the end of the runway at 5 feet. Aircraft continued to sink normally, until main gear was one foot in the air. Aircraft was held in this attitude until final touchdown. Just prior to touchdown, the left wing was slightly low. Aircraft touched down just short of the 1000 foot marker. Immediately after touchdown the aircraft started to the left. I called for right rudder. Rudder was applied instantly, and held until aircraft stopped. After only 100-200 feet of rollout, the left wing skid was in contact with the runway, and remained down throughout rollout, and turning movement was increasing rapidly.

It was immediately obvious to me that directional control could not be regained. I called for stopcock, and pilot again responded rapidly. After 200 feet or so, aircraft was skidding, or sliding. That is, the tail was well out of track with the main gear. This "Out of Trail" condition increased until aircraft entered soft sand by the runway. Aircraft stopped very near runway, with no serious apparent damage.

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[REDACTED]



STATEMENT OF [REDACTED]

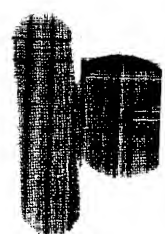
25X1A

13 November 1968

On 13 Nov I was the Operations Officer in the Mobile vehicle with [REDACTED] and Andy when David made his landing in 057. Up to the point of touch down all indications were normal. David had made several calls to the tower regarding the landing runway and winds. Runway 24 was selected because the wind was mostly calm with occasional wind from 220 at 2 or 3 knots. After a normal traffic pattern 057 arrived over the overrun and began receiving altitude information from the Mobile Officer. Initially he started flair at 10 feet descending slowly to 1 foot. At this point the aircraft started to settle. As the aircraft started down the left wing appeared to stall. Contact with the runway was by main gear and tail wheel followed immediately by the left tip. After touch down the aircraft started a left turning skid. Mobile called for full right rudder, which was already applied, followed by a call to stop cock when it became apparent the aircraft would leave the runway. The decision to abort was made immediately since the skid developed very rapidly and a successful go-around would have been doubtful.

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The aircraft continued the left turning skid with the left wing down and left the runway approximately 800 feet beyond the touch down point. It came to rest about 100 feet off the hard surface in soft sand having turned 90 degrees left from landing heading. There was no fire or major damage to the aircraft. The pilot evacuated the cockpit without incident.



15 November 1968

STATEMENT

25X1A At 0805 hours on 13 November 1968, I performed a preflight medical evaluation on [REDACTED] (David). All aspects of this evaluation were normal. Immediately upon completing this evaluation, I observed David to proceed to the suiting/prebreathing area in the Personal Equipment Section where he was suited and started on his denitrogenation. He started his prebreathing at one hour fifteen minutes prior to scheduled takeoff time and personal equipment preflight checks were all normal.

After takeoff, I made two visits to the Command Post Section in Operations during the morning to inquire if everything was normal on David's flight, and was told on both occasions that everything was normal and David had no complaints.

At 1215 hours on 13 November, I departed the Life Support Section and proceeded to the Physiological Training Unit on Main Base to provide Flight Surgeon coverage for altitude chamber training for [REDACTED]

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25X1A At 1355 hours, at the completion of these chamber runs, I departed for North Base. At 1400 hours, as I was approaching [REDACTED] on Main Base, I heard over the G.E. radio receiver in my vehicle a call from Mobile to Vestibule to have [REDACTED] come out to the runway because "we have trouble out here". Within the next few seconds, there was a second call for Maintenance, [REDACTED] and [REDACTED]. Within another minute, I was called by [REDACTED] and asked to come out. I advised that I was practically there. At 1405 I arrived at the site of the incident to observe the aircraft off the runway and the pilot being assisted out of the cockpit.

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25X1A When I reached the side of the ladder, I observed the pilot to be David. His helmet was off, and he was being assisted in walking by [REDACTED] and [REDACTED] was conscious, but appeared to be somewhat confused. As we were putting him in the field ambulance, David was shaking his head from side to side and saying, "What have I done?"

25X1A

We proceeded to the Medical Section, and having determined enroute that David did not appear to be seriously injured, had the personal equipment technicians remove the remainder of his pressure suit as soon as we arrived at the building in order to be able to examine him more completely.

At 1410 hours, I conducted a complete physical examination on David. His vital signs were all normal, and remained normal. He complained of pain in the back of his neck, some dizziness, and weakness. He was conscious throughout, and his answers to questions were appropriate.

Atch "0"

Blood samples were taken for multiple analyses, including complete blood count, carbon monoxide, alcohol, glucose, carbon dioxide, BUN, and electrolytes. All these examinations have subsequently been reported as well within normal limits. At the conclusion of my examination, my impression was that the only injury was perhaps a strain of the posterior cervical muscles of the neck. Because David was still complaining of some generalized weakness, dizziness, and headache, and even though his physical examination was essentially normal, I decided to hospitalize him for observation to make sure he was not having some manifestations of central nervous system dysbarism ("CNS Bends").

Arrangements were made with the assistance of [REDACTED] (I-3), the Main Base Hospital Commander, for David to be admitted under my care, and to be provided with a private room. All arrangements were made with the concurrence of the Security Section. David was hospitalized around 1630 hours, and, at my request, was seen in consultation by [REDACTED], the internal medicine specialist at the hospital, who performed a complete physical examination, including a detailed neurological evaluation. His conclusions were that David had spasm of his posterior cervical muscles, and that the headache and dizziness were probably related to this muscle strain.

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David was placed on bed rest throughout the night, and frequent monitorings of his temperature, pulse, blood pressure, and general condition were done. All were normal, except around 2200 hours, he began to run a slight fever (99.6 degrees F.), and complained of his whole body feeling warm and some muscle aching. His temperature returned to normal within the next four hours, without medication.

When seen again by the undersigned at 0700 hours on 14 November, David was afebrile and stated he felt "much better". There were no complaints of dizziness, weakness, or headache. There was still some cervical muscle tenderness and spasm. He now had very minimal nasal congestion, and said he felt as if he might be "coming down with a cold". David was seen again by [REDACTED] around 0800 hours, and we both agreed that there was no evidence of any central nervous system involvement. David was discharged to my care as an outpatient. Complete blood count done again prior to discharge was again normal, and chest X-ray performed the morning of discharge was normal.

25X1A

David was placed on quarters and given some medications for his mild upper respiratory infection. He monitored his temperatures at home throughout the next twenty four hours, and it remained normal. He was examined again by me at 1030 hours on 15 November, and at this time showed a little more evidence of a minor upper respiratory infection.

His cervical muscle spasm had improved with aspirin and use of a heating pad locally. At this time, we had a detailed discussion of the events that occurred on 13 November, and he had excellent recollection of even minor details prior to, during, and after the incident.

CONCLUSIONS:

- 25X1A
- 1.) Physical condition of [REDACTED] (David) normal up to incident that occurred on landing, 1400 hours, 13 November 1968.
 - 2.) Rapid deceleration of article after it left the runway caused subject to pitch forward and sustain strain of cervical muscles, back of neck. Dizziness, weakness, and posterior headache secondary to above cervical strain and psychological "shock" of incident.
 - 3.) Failure of subject to have shoulder restraints locked prior to landing may have contributed to cervical strain, but rapid deceleration would probably have caused head to pitch forward to some degree, even if shoulder harness locked.
 - 4.) No evidence of any type of dysbarism or other injury. Hypoxia, fatigue, or disorientation not a factor in this incident.
 - 5.) All personal equipment functioned normally.
 - 6.) The mild upper respiratory infection, probably viral, that developed around eight hours after the incident is felt to be coincidental and not related to the incident.
- 25X1A

Respectfully submitted:

[REDACTED]

S T A T E M E N T

13 November 1968

At approximately 1400 hours on 13 November 1968, I the undersigned was standing by for the landing of [REDACTED]. His approach seemed normal including his touch down. Upon his landing roll his left wing was observed to dip down sharply striking the runway and remaining in this position. Within seconds the aircraft made a sharp left turn, leaving the runway and proceeding into the desert area at a distance of about 150 feet. The landing gear either collapsed or sunk into the dirt of which I am not sure. I proceeded to the accident and arrived just as the maintenance men were setting up the step-ladder beside the aircraft. At this point [REDACTED] and I mounted the ladder at the same time. The canopy was still closed and locked. David was observed by me to be looking straight ahead with his head tilted slightly forward. He was not moving and his face cover was open. After knocking on the canopy to attract his attention, I indicated for him to unlock the canopy. He seemed dazed and his eyes had a lackluster appearance. After a few repeated motions to open the canopy latch he finally did so. When the canopy was raised he began to feel around the right side panel located at the seat level. Seeing that the safety pins were still out I ask him to raise his hands to which he replied "What happened here". After I got his hands to the outside I ask [REDACTED] the P.E. technician to come up and unhook him. David again moved his hands down to his lap. [REDACTED] ask David to put his hands up so he could put the safety pins in and unhook him. David did not respond, so [REDACTED] manually placed his hands up to the side of the cockpit. After the pins were installed and David was unhooked I questioned David as to any injuries he had, his feelings as to just what happened. He gave no verbal response and seemed to be completely incoherent of what was going on about him. He could not give me his name upon request. I ask [REDACTED] to remove his helmet and right glove thus allowing me to examine his head for injury and to take his pulse. Examination revealed the following information. There were no signs of traumatic head injury, his eyes were pin-point and equal, pulse rate was 78 per minute. His face was damp and ashen in color indicating shock, finger nails revealed no signs of cyanosis. At this point David again without any prompting remarked, "what have I done"? [REDACTED] was instructed by me to contact [REDACTED] by radio and ask him to come out for assistance. [REDACTED] and I began to remove David from the cockpit. David was able at this point to help himself get out. He was about half way out when [REDACTED] arrived and after getting to the ground, he was checked visually by [REDACTED] placed into the ambulance and taken to the [REDACTED] medical section. I assisted [REDACTED] with a completed examination of the patient. His initial blood pressure was 132/74. Blood was drawn by the undersigned at the request of [REDACTED] from the subject for the purpose of obtaining laboratory evaluations.

The above information is true to the best of my knowledge pertaining to the aircraft accident involving [REDACTED]

[REDACTED]

STATEMENT OF FACT

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██████████ reported for dressing and pre-breathing at 08:05 and was put on the hose at 08:15. The subject pre-breathed for 1:15 prior to take off. The pressurization check of his equipment checked out normal prior to his leaving the personal equipment section for the aircraft. The cockpit hook-up and pressure check was normal.

I observed aircraft 057 make what appeared to be a normal touch down at approximately 1400 hours. I glanced away momentarily and when I looked back, the aircraft was sliding sideways down the runway. When I saw the aircraft sliding down the runway, I started in the direction of the aircraft. I was the third man to reach the article. The pilot seemed to be in a dazed condition and the canopy was still locked down. The crew chief made some motions to the pilot and he finally unlocked the canopy. I then installed the seat pins. ██████████ was on the ladder beside me and asked the pilot where he hurt. He answered in a dazed condition, "I'll be all right". We told him to sit still and I unstrapped him from the seat. I had to lift the pilot's hands and arms out of the way so I could unhook him. All the connections were engaged, his oxygen was shut off and his visor was open. I unlocked his helmet and removed it. I then took his gloves off. We then let him sit in the aircraft for a couple of minutes while ██████████ took his pulse and observed him. I then reached down to disconnect his spurs but they were already disconnected. We then asked him if he could stand up and get out of the aircraft. He did so very slowly with ██████████ and I assisting him. He sat on top of the ladder and we removed his spurs from his boots. We helped him down the ladder and into the ambulance. Approximately seven to eight minutes elapsed from the time I reached the cockpit until the subject was out of the aircraft and into the ambulance.

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While he was being taken to the P.E. building in the ambulance, I took the parachute and seat kit from the aircraft. The remaining oxygen indicated on the quantity gages was 8.5 liters on both systems. I didn't notice whether the inertia reel was in locked position when I removed the shoulder harness. I went back to the aircraft with [REDACTED] to check and it was unlocked.

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The post flight inspection of the pressure suit, helmet, gloves, parachute, seat kit, boots, and shoulder harness indicated that every thing was in a serviceable condition.

To the best of my knowledge, the above information is correct.

25X1A

[REDACTED]

13 Nov. 1968

SHIP # 057 ~

HARD LANDING

LANDING GEAR:—

ON BOTH GEARS ON THE SHIP:—

1. CHECK BOLT TORQUE ON TRUNNION CAPS & NOTE.
2. EXAMINE VISUALLY WITH A GLASS THE TRUNNION FITTINGS FIXED IN THE SHIP.

IN THE GEAR SHOP:—

A. MAIN GEAR

1. CLEAN UP & DISASSEMBLE
2. CHECK INTERNAL BEARINGS FOR DEFORMATION.
3. DYE CHECK CYLINDER TRUNNIONS
4. EXAMINE CYLINDER LOWER BRG. AREA FOR DISTORTION
5. DYE CHECK PISTON-AXLE INTERSECTION & CHECK FOR PERMANENT DEFLECTIONS
6. DYE CHECK TORQUE ARM LUGS ON THE CYLINDER & TORQUE ARMS. CHECK ALL HOLES FOR SIZE & TORQUE ARM PINS FOR CRANK-SHAFTING
7. CHECK DRAG STRUT VISUALLY

B.

TAIL GEAR:—

SAME AS ITEMS 1-7 ABOVE.

8. REPLACE WHEELS & BEARINGS
9. ZYGLO AXLE

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Str. Eng.

Atch E

ARD LANDING

057 FUS STRUCT 11-14-68

Remove M.L.G. Trunnion caps check
torque on Bolts Before Removal

2990 Trunnion caps & Replace
Trunnion Bolts on L.H. Trunnion

Inspect Trunnion Bushings for
Possible Damage

Dye check any Area on Trunnion
Support Fittings That looks Like
a possible crack. (REF. REF 48 Bulb)
(ASSEM FUS-STA 402)

AFTER GEAR & DRAGLINK IS REMOVED
INSPECT DRAG LINK SUPPORT STRUCTURE
BETWEEN DUCTS with glass for
Possible cracks. Dye check any Area
That looks Like Possible crack.
(FUS - STA. 379)

~~ALL~~ All structure Area Looks good.
No Tilted Rivets Noted.

Lower Hatch Removed. No Damage
Noted in Hatch AREA.

11-14-68

25X1A

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2. [REDACTED]

C.C.

[REDACTED]

25X1A

30M: [REDACTED]

25X1A

OBJ.: SURVEY OF 057 LEFT WING.

I DETECTED NO STRUCTURAL DAMAGE
WHATEVER. SUCH DAMAGE AS DID OCCUR
IS MINOR AND CONFINED TO NON-STRUCTURAL
PARTS..

2. WING TIP & SKID.

a. STEEL SHOE IS DEFORMED - MAY BE
STRAIGHTENED OR REPLACED.

b. CRACK IN L.E. SKIN FAIRING AT W.S. 550;
STOP DRILL & INSTALL 1/8 CISK RIVET.

c. LUG BOLTS AT W.S. 550 JOINT CAME OUT
NORMALLY. SUGGEST CLOSE VISUAL INSP-
ECTION OF LUGS, BUT ANTICIPATE NO PROBLEM.

3. FLAP T.E.

a. CLOSURE STRIPS AT T.E. BETWEEN #3 & #4
FLAP SECTIONS DAMAGED. STRAIGHTEN AS
REQ'D. IF UNDERNEATH PART CRACKS, CUT
OFF AND ADD PATCH WITH AD3 RIVETS.

[REDACTED]

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11-14-8

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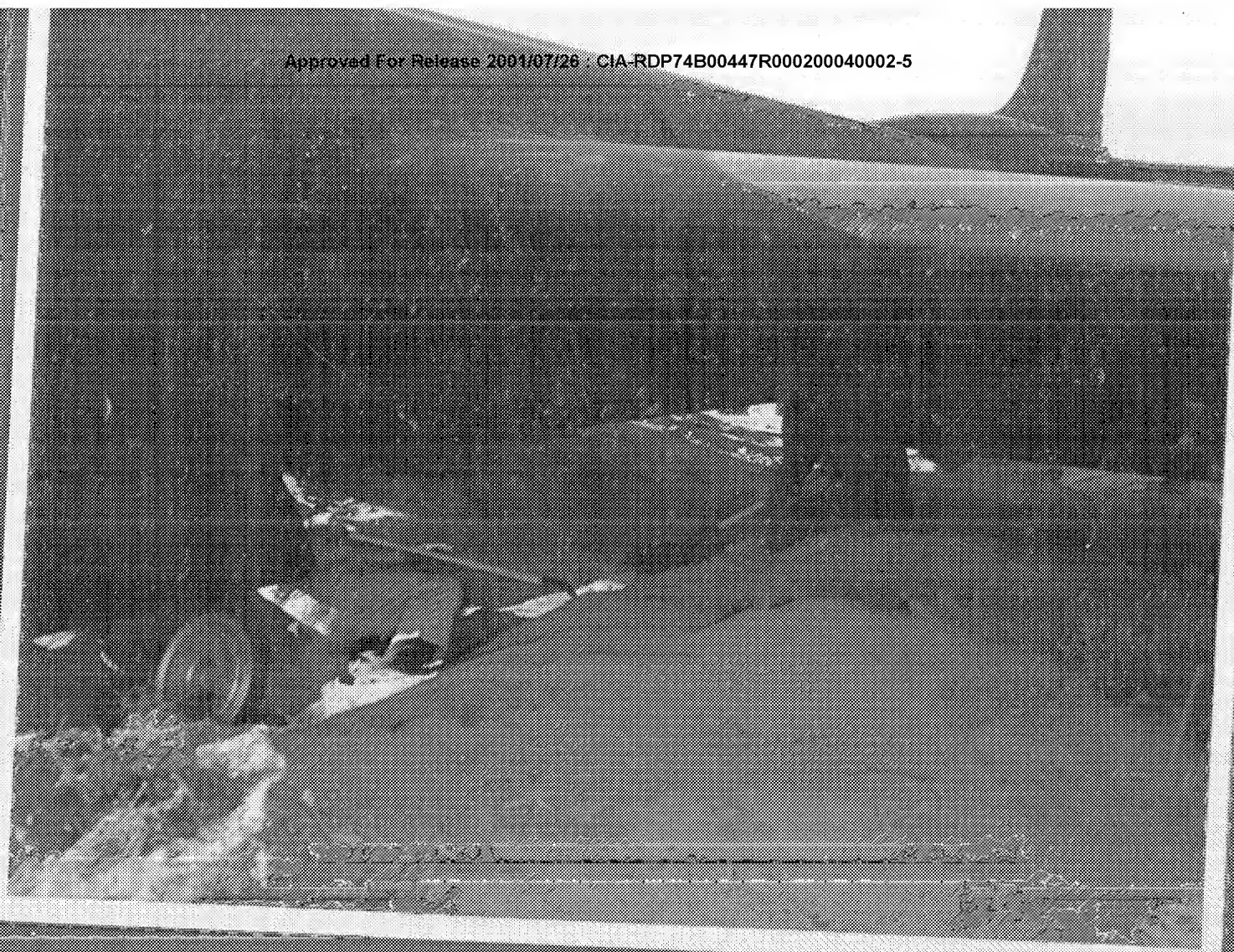
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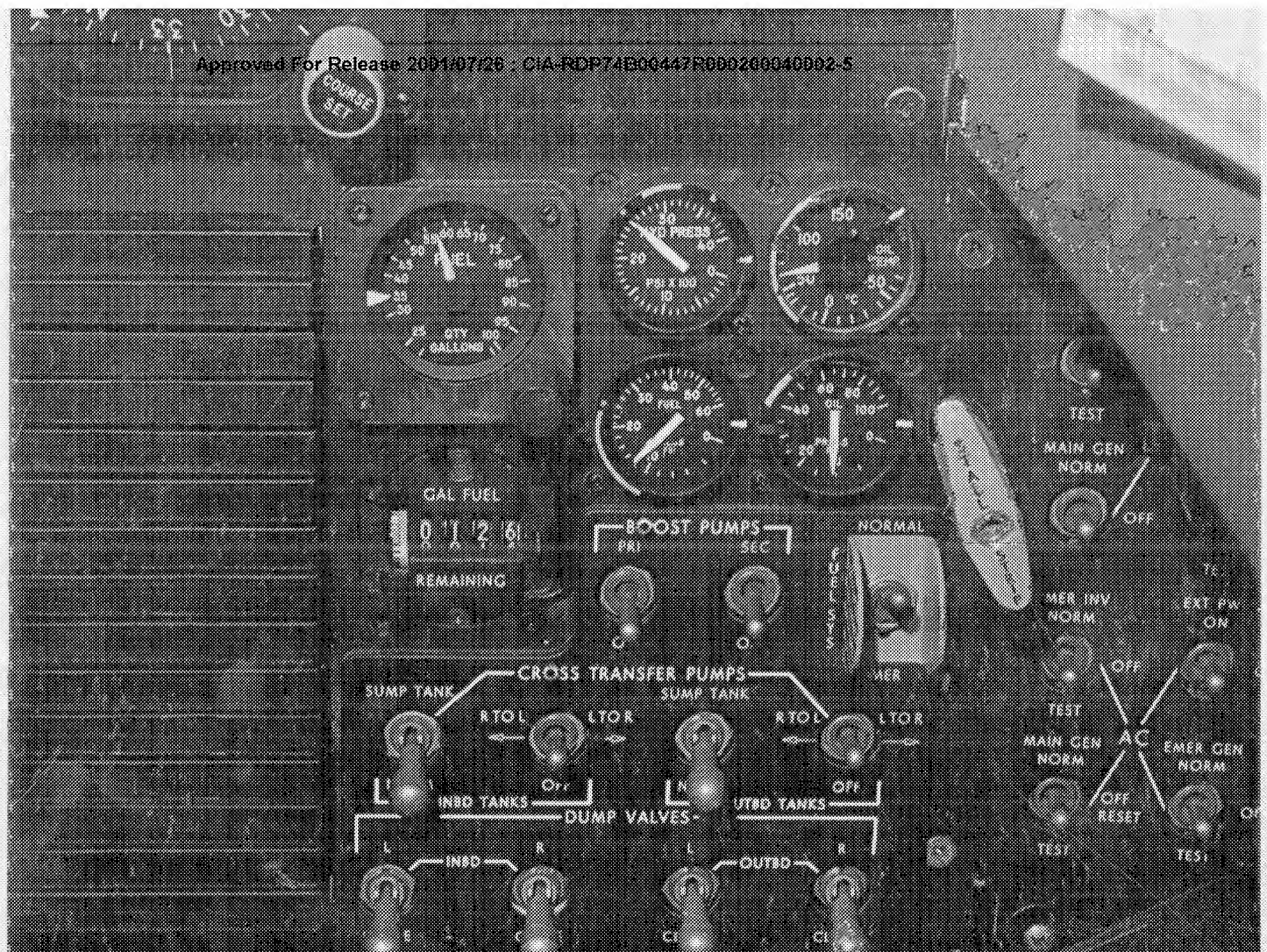


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